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The Myth of Mental Illness

A conversation with Thomas Szasz

by JONATHAN MILLER

PSYCHIATRISTS such as R.D. Laing have argued that mental illness represents an eloquent protest on the part of the patient, and that psychosis enables the sufferer to escape from the intolerable psychological pressures exerted by tyrannical families and uncaring societies. Laing and his followers insist that the physical treatment of these illnesses is an elaborate way of evading the political issues involved, and that therapeutic regimes in modern hospitals express the ideals of a society eager to see its members behave in a conveniently decorous and economically productive manner.

A somewhat different approach is taken by the American psychiatrist Thomas Szasz, who argues that madness has been misrepresented as a disease, and that the myth of mental illness has given the medical profession a dangerously unlimited license to imprison and manipulate mad people in the name of philanthropy. For Szasz and his followers, the classification of madness as a disease represents a tragic error of philosophical judgment, and in a long list of books published over the last twenty-five years he has argued that the failure to recognize this error has led to the loss of a precious human birthright.

Miller: When someone coins a vivid slogan, he often becomes associated with it for the rest of his life. Your name is associated with the idea that mental illness is a myth. What do you mean by the "myth of mental illness"?

Szasz: I mean the same sort of thing that the philosopher Gilbert Ryle means by a category error. The liver can be sick; the heart can be sick; the brain can be sick—using sick in the modern scientific sense, meaning that there is something biologically amiss with a part of the body. Since the mind is not a part of the body, is not an organ—since the mind is an abstract noun that lacks a concrete referent—it cannot be sick. It's as simple as that.

Of course, the term mental illness means something. But what it means is very different from what it's supposed to mean. For decades, the American people have been bombarded with the message that "mental illness is like any other illness." That is the official, supposedly scientific position. Well, the one thing that's obvious about mental illness is that it is not like any other illness. In my view, it's not an illness at all.

Miller: So you're saying then, in Ryle's sense, that we've mistaken the categories of illness by applying it to the mind. You feel that this is logically wrong as well as factually wrong.

Szasz: That's correct. But to say that the idea of mental illness is a mistake is true only in a very benign philosophical sense. Because, in a sense, it's not really a mistake: nearly everyone knows that mental illness is not like cancer or heart disease. The whole history of psychiatry shows that the way mental illness is talked about is a particular way of using language to gain certain practical ends. So instead of talking about mental illness, we should talk about what doctors, surgeons, and psychiatrists *do*.

To use some philosophical concepts again, we now know, or understand, that, empirically, a word means the habits it involves or engenders. We must stick to that, especially when it comes to psychiatric words. There is not much point in looking up such words, any kinds of words, in dictionaries. If you want to know what a word really means, you have got to know how people actually use it. Because that's what it means.

Miller: So, how and when was the notion of sickness first applied or *mis*applied to the mind?

Szasz: That's easy to answer and it ties right in with my argument. The idea of illness as applied to the mind is roughly coeval with the idea of illness, in the modern sense, as applied to the body. Without going into too

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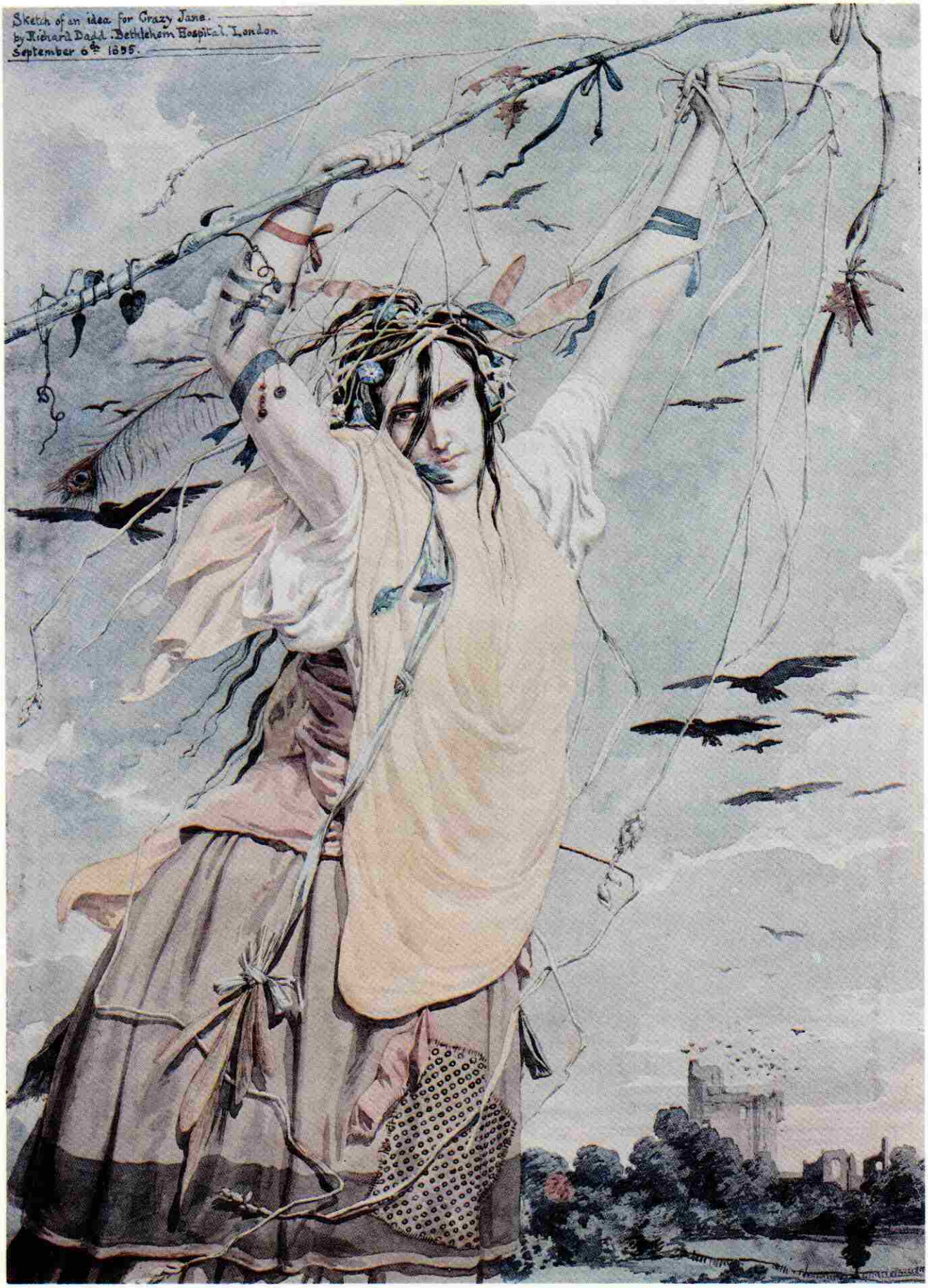
Bethlem Royal Hospital, Kent, England



Richard Dadd,* Crazy Jane, *1855

many details, remember that up to the end of the eighteenth century—say, until 1800—doctors and scientists believed that a person was ill when he suffered from various disturbances of what were called the humors. It really wasn't until after the Enlightenment—actually not until about 1850, when medical microscopy developed—that a wholly different concept of disease arose: that is, the concept of disease as tissue damage, as bodily illness. It was during this same period, when the medical concept of illness changed from the humoral to the cellular, as Rudolph Virchow put it, that the idea of insanity changed from madness to mental illness.

But we must connect all this with an operational approach to mental illness, to psychiatry. Psychiatrists traditionally and typically have operated mental institutions, called madhouses or mental hospitals, and confined people in buildings so labeled. Ostensibly, inmates were confined for the treatment of their mental illnesses. But that wasn't the real reason.

Miller: But prior to the identification of the mad with the sick, the custody of the mad was not necessarily legitimized in terms of illness or sickness. It had to do with the protection of the individual, or the protection of society, from the mad person. But you're saying that, with the advent of pathological notions of tissues and organs in physical disease, this extended to include madness, and that the mad person was now put in custody as a *sick* person rather than as an aberrant one.

Szasz: That's right. We can't really speak of the custody of madness before the modern era, because there were no madhouses or mental hospitals, to speak of, before the middle of the seventeenth century. In England there was Bedlam, of course. But that institution served a variety of purposes; housing the insane was just one of them. If we go back in history, say to classical Rome at its height, we find that it was a city of about two million people—and it had no institutions for housing mad people. The same holds for ancient Greece. The point is that the increase in mental patients occurred in tandem, as it were, with the development of mental hospitals. The buildings, the patients, and the psychiatrists grew together, one after the other.

Miller: So, you're saying then that the patient is a creation of the psychiatrist.

Szasz: I hope that's not too shocking. It's a simple idea, really, similar to the idea that the heretic is a creation of the theologian. Obviously, if there is no dogmatic, militant religion, there is no heresy and there are no heretics.

Miller: And you're also insisting that the development of the psychiatrist in turn is the consequence of the misapplication of pathological ideas to the mind. Now why do you think, in the middle of the eighteenth century, it became necessary or attractive to categorize madness as the expression of sickness, rather than as some other denomination?

Szasz: Well, that ties in both with the development of the idea of illness and with the development, in Western culture, of urbanization and the resulting problems of pauperism, vagrancy, and so forth. We are talking now, in a way, about the earliest form of the problem of unemployment. I am oversimplifying, but this is the central problem of psychiatry: people in society who somehow can't make it; who don't make it; who are, or who have become, outsiders. This image is captured very nicely in the old-fashioned English term "alienation." In the eighteenth century, the victims, the clients, the patients—it's hard to know what to call them—were alienated. The doctors who became their managers were called alienists. That's what mad-doctoring was all about. That's what psychiatry is still all about.

But there is something sticky about all this. We are talking about the eighteenth century, not the Middle Ages or biblical times. We are talking about the West, where there was already a sense that you can't just sweep people off the streets and lock them up—unless they are criminals. But society—the dominant class of society—was now confronted with a lot of people who didn't fit in, who had no place in society, who had lost their place in society—but who were not criminals. What justified locking them up? Illness.

In my opinion, illness—and especially mental illness—is one of the core concepts in the justificatory rhetoric of the modern world. It replaces God, in a way. In the name of God, people waged wars, killed, and enslaved others. Religion justified all. Now medicine does. Now people are locked up in the name of mental illness. When the Russians do that, journalists in America and England say, "That's awful, they are locking up dissidents." That's not the way the Russians see it, of course. They say they are locking up schizophrenics. The sad part of it is that long before *they* did it, *we,* in the West, did it. Of course, we were not "locking" up innocent persons, we were "hospitalizing" mental patients. And that's what we do today.

Miller: So you're saying that the justification for putting away the awkward, the unpleasant, the disgusting or . . .

Szasz: The helpless.

Miller: . . . or the helpless . . .

Szasz: . . . and the hopeless and the lonely . . .

Miller: . . . was in fact pathological, and that they had to be identified as ill before people felt justified in putting them away.

Szasz: Right. We see this idea developing already in Shakespeare's plays, at the very dawn—even before the dawn—of psychiatry. Hamlet's mother and uncle, for example, tried to get rid of him by classifying him as mad, but it wasn't so easy. No one locked up Lear, either, though he had what psychiatrists would now call a mental illness.

Miller: And you go on to insist then that this is a disguised form of social control and that it's the exercise of a tyranny. Medicine has tyrannized the individual.

Szasz: Well, yes, but it's even more complicated than that. Of course, psychiatric controls are a form of tyranny; but they are a form of protection, too. I'm not softening my position, but I have always emphasized that psychiatric tyranny, like so many tyrannies, is a type of paternalism. Psychiatric controls satisfy two kinds of needs. On the one hand, psychiatrists help families, help society, by removing certain unpleasant or unmanageable people from their midst. On the other hand, psychiatrists also

The Tate Gallery, London

William Blake, **Nebuchadnezzar,** *1795*

help individuals by providing housing and care—really, room and board—for people who can't or won't take care of themselves. In Calcutta, people live on the streets. You can't do that in London or New York, though in New York it's going a bit that way now. So in London and New York, the outcasts and the homeless end up in mental hospitals. Many of these people may be ambivalent about this arrangement: they may not want to be there but they have no better alternative. That is why, if psychiatric hospitals are halfway pleasant, psychiatrists have trouble getting people discharged. These so-called hospitals are really homes for the homeless. They are orphanages for abandoned, solitary adults. It's a very sad affair, really. And what makes it sadder still, and economically ruinous and conceptually unmanageable in our society, is that this whole business is medicalized. The inmates are supposed to have mental illnesses, are supposed to get treatments for these illnesses, and so on. Everyone is looking for an illness where there isn't one. Just miserable, tragic lives.

Miller: But is it merely because it's economically unviable that you regard the medicalization of madness as objectionable, or do you think that there's some more fundamental ethical reason for removing the medical from the domain of the insane?

Szasz: Both. I object to the medicalization undergirding—or, better, inspiriting—psychiatry for both economic and ethical reasons. And for conceptual reasons, too, of course. But I think that's too abstract. Let's get back to what the psychiatrist does. The psychiatrist is a doctor, a physician. But what does he do? He takes innocent persons and deprives them of liberty; that's called civil commitment. And he takes guilty persons and claims that they are innocent; that's called the insanity defense. Ostensibly, both of these things are done in the name of diagnosing and treating mental illness. That's the ideology. That's the justification. But the fact remains that psychiatrists incriminate the innocent and excuse the guilty. Therein, precisely, lies much of their power.

Miller: Perhaps I can take the legal case first, and offer an objection. Wouldn't it be true to say that until the abolition of capital punishment at least, the psychiatrist was not, in fact, proving a murderer's *innocence,* but was being humane in offering some sort of mitigation. It was a life-saving maneuver, because at least it saved these wretches from the gallows; and in that sense the psychiatrist was not simply inflicting a medical category on someone who ought to have been punished. He was softening the violence of a vindictive law.

Szasz: Of course, you're right. You know your medical history. That is what happened and *that,* by the way, is one of the reasons psychiatrists have acquired, from early on, the mantle of being humanists. This sort of softening of the laws—really, evasion of the laws—has continued to

the present day. For example, before abortion on demand became legal in America about ten years ago, a pregnant woman who wanted an abortion had a choice between an illegal abortion and a legal one. She could go to a psychiatrist and, in effect, pay him to declare that she needed a "therapeutic" abortion. I wrote about that, many years ago, and called it bootlegging humanism.

So far so good. But social life is a complex dialectical process. Ideas have consequences. In the nineteenth century, psychiatrists used the insanity defense to save criminals from the gallows. But if they objected to capital punishment, why didn't they—why didn't the British Psychiatric Association or the American Psychiatric Association—lobby against capital punishment? Why did they instead lie about mental diseases? Such lobbying would have been genuinely altruistic. But it would not have given them the mystique and the power, as professionals, that they craved. That they still crave.

Actually, what the nineteenth-century psychiatrists who called murderers insane did had nothing to do with medicine or science. They were actually struggling against capital punishment. But capital punishment is no longer a serious problem. In most western countries it is, for all practical purposes, a thing of the past. Yet psychiatrists still insist that murderers—and, of course, all kinds of other persons who break the law, too—are mentally ill. Moreover, many psychiatrists do not merely want to save people from execution, they want to save them from all penal sanctions.

Take the case of the Yorkshire Ripper. Several psychiatrists testified that he was not responsible for the killings because he was sick. It seems likely that they genuinely believed that the Yorkshire Ripper killed women because he had a disease, just as some people have sugar in their urine because they have diabetes. This is what I mean when I say that ideas have consequences. The idea of mental illness has consequences. It may have started out as a metaphor and a strategy, but now it has become real. The metaphor is now taken literally, which is one of the reasons I believe that psychiatry is much like a religion.

Miller: Well, let's concede that certain forms of insanity may not be as readily identifiable with a physical pathology as, say, jaundice, which can be identified with a disorder of the liver, and be discovered at autopsy; and let's say that psychiatrists have found it very hard to associate certain aberrations of behavior with corresponding disorders of the brain.

But wouldn't it be reasonable to say that certain forms of conduct are so consistently unrepresentative of the main mass of human behavior—like ripping ladies, and going out and doing it again and again in a compulsive way—and are so similar to disease, in the sense that they exhibit a certain sort of coherent consistency, that it's only hair-splitting to say that it's not a disease because you can't find some sort of organic lesion associated with it. Isn't the fact that someone is compelled to go on acting out some antisocial violence in itself enough to justify calling it a disorder, and indeed an illness?

Szasz: That is a very forceful way of framing the argument—the argument against *my* view, that is. Everything you said is plausible. But, let me try to sort out what is problematic—to put it mildly—about it. First of all, implicit in your argument is a subtle switching of the ground rules about what constitutes disease. Biological scientists and nonpsychiatric physicians continue to stick to the idea that a disease is a demonstrable lesion, not a package of behaviors. That was the definition I used too. You are, in effect, suggesting another definition.

You have also introduced the concept of behaviors that exhibit a "coherent consistency." Now, that will prove to be troublesome because there are all kinds of assemblages or configurations of behaviors that exhibit such coherence and consistency and that we do not call diseases. For example, religious behavior. If a person doesn't share the religious beliefs that inspire the behaviors he observes, then such behaviors may very well seem strange or peculiar to him. He may even call the religion a cult. It is quite popular now in the United States for psychiatrists to call certain minority religions cults and to diagnose their adherents as suffering from mental illnesses. Of course, before it became a dominant religion, Christianity itself was a minority religion—a cult, if you like. My point is that you have provided no guidance about how we should distinguish between those assemblages of behavior that are diseases, or that may be diseases, and those that are not, those that we need not suspect of being diseases.

Finally, you introduced the idea of law-breaking, of violence, as a disease. That I don't like at all. I think it's a serious mistake to intermingle crime and disease. Crime is crime and disease is disease. One quick way to see the trouble we create for ourselves in mixing these categories is by coming back, once more, to the question of the doctor's duty. Is it his duty to help people recover from diseases? Or is it his duty to enforce the law and punish people? Obviously, if someone goes around killing women, like the Yorkshire Ripper did, once he is caught, any civilized society will do something to him. Even if what's done to him is called hospitalization or treatment, the subject will experience it as punishment.

Miller: Simply in the sense that his liberty is curtailed?

Szasz: Isn't that enough? Of course, he may suffer other indignities or punishments. He may be forced to ingest chemicals. He may be subjected to various interventions called psychiatric treatments. But talking about those things will get us off target. Let's stick to liberty, to the deprivation of liberty. Is it the proper function of a doctor to deprive a person of liberty?

Miller: No, but it may be a doctor's function, in cases where there are unpleasantly violent penalties to be inflicted for such crimes, to exert an advocacy on behalf of the subject, simply to make sure that he does not suffer such violent penalties.

Szasz: I don't believe that. I don't like that. After all, a doctor, like anyone else in modern society, is primarily an individual moral agent, a citizen. Only secondarily is he a doctor. Now, in his role as a citizen, it is his job to exert the sort of advocacy you speak of, to do the morally right thing, whatever that may be for him: protesting against irrational or vicious laws, sacrificing his life . . . leaving the country. . . . If you are a conscientious doctor in Nazi Germany, then, I would say, the thing to do is to leave, to go to America, rather than to practice in that system.

Miller: You seem to hinge much of your argument on the

existence of some objectively identifiable lesion. If someone has jaundice and nausea and pale stools and so forth, we would expect to find corresponding disorders in the liver. But let's go back to the days *before* the findings at autopsy in the liver had been shown to have an association with the cluster of symptoms that a patient presented in the hospital. Now you wouldn't want to say that before the liver had been identified as the source of the illness, a patient with jaundice, nausea, and so forth, was *not* in fact sick?

Szasz: Of course not.

Miller: Well, in exactly the same way, might it not be the case that certain consistencies of aberrant conduct and thought were regarded as illnesses even though it was impossible at this particular point in time to find a lesion at autopsy?

Szasz: Let's assume for a minute that that is the case—that certain identifiable patterns of behavior, which psychiatrists now call schizophrenia, are indeed the symptoms of a very subtle disease of the nervous system. The question remains: What would happen if this were so? What would be the consequences? After all, there is no point in arguing about words; but there is a point in arguing about deeds. The consequences of treating schizophrenia as a real disease, as a brain disease, would be of two kinds: one would concern the so-called patient, what that person would do about it; the other would concern society, what other people would do about it.

If schizophrenia is an illness, if we are going to use the medical model—we are talking about patients in England or America, not Russia—then it follows, doesn't it, that the patient is a free agent. Just as if he had, say, pneumonia. So you tell the patient: "Mr. Jones, you have got pneumonia, you should take some penicillin for it." And the patient says: "Thank you, Dr. Miller, but I don't like penicillin. I'll go home and take aspirin." Now, psychiatrists tell schizophrenics to take thorazine. And the patients often say, "No I won't take thorazine." Okay? Next chapter.

Now, let's assume that this gentleman with schizophrenia kills his wife. Why should he be able to plead schizophrenia as an excuse for such a crime, but not be able to plead diabetes or Parkinsonism, for that matter? Why should mental illness be an excuse for crime, but not bodily illness? You see, although I don't think schizophrenia is a disease, I don't have any objection to treating it, in some ways, *as if* it were a disease. But if schizophrenia were a disease, "like any other," then it would not be an excusing condition for crime, as it now is.

Miller: All right, if we can leave the juridical questions on one side for the moment . . .

Szasz: We can't do that because psychiatry *is* juridical, through and through. We can only pretend to leave out the juridical.

Miller: But if we can leave the more confined aspects of the juridical, in the sense of the . . .

Szasz: The juridical hangs over psychiatry. Like a pall. You know *Mrs. Dalloway*?

Miller: Indeed.

Szasz: Well, what more is there to say? When a social worker tells poor Mrs. Jones to come to the hospital, she goes along meekly. Mrs. Jones knows very well that she can't successfully resist such an invitation, that the social worker can get the machinery rolling to get her certified.

So long as there are laws for involuntary mental hospitalization, there can be no truly voluntary mental-hospital patients. Strictly speaking, there are no voluntary mental-hospital patients in Great Britain—even though most of them are officially, ostensibly, voluntary. Just as there are no voluntary taxpayers. Of course, we all pay our taxes—in order not to go to jail. I don't call that a voluntary act.

Miller: You mean that because there is the threat of *involuntary* commitment . . .

Szasz: Indeed. Because of the threat of compulsory hospitalization; because of the long history of it; because of the harsh reality of it, it's not an empty threat.

Miller: I agree with you, that there is always the threat of the tyranny of involuntary commitment—of simply taking away someone's liberty merely because you have identified him one way rather than the other. But what do you do about those people who have become mad, and mad in a way that renders them incapable of asking for the help that the medical profession might be able to provide?

Szasz: Your question is, again, very well taken. This is precisely why psychiatry is such an important social institution, and why psychiatrists are so powerful. Because they *are* useful. I like to paraphrase Voltaire, in this connection. Voltaire, you remember, said that if there were no God, it would be necessary to invent him. Well, if there were no psychiatry, no mental illness, it would be necessary to invent it. Because, today, it is psychiatry, not religion, that comes to the rescue in many existentially difficult, tragic situations. Whether the way psychiatry resolves certain tough, vexing situations is the best way to resolve them; whether we could do better differently, without psychiatry—well, that is certainly debatable. Honest people can have honest differences about that.

You emphasized the patient's—the so-called patient's—helplessness, his inability to act as his own agent, to seek help. Now, that's certainly a part of the problem. It's a tusk or a leg, but it is surely not the whole elephant. Actually, insofar as people are so helpless that they cannot seek help—there is no great problem. In this respect, there is no difference between my views and the views of other psychiatrists. I believe that such a person should be treated pretty much the same way that a person knocked unconscious by a taxi is treated. The ordinary channels of medicine, law, compassion, and decency should be opened. The resources available in society should be mobilized on his behalf. He should be treated and cared for in whatever way makes sense in and to that society—humanely, caringly, therapeutically.

Miller: I see that.

Szasz: But this sort of problem makes up only a very small part of psychiatric practice. It is a minuscule part of the psychiatric elephant, so to speak; it is not a tusk or a leg, it's more like a toenail—if the elephant has a toenail. Be-

The National Library of Medicine, Bethesda

William Hogarth, **Bethlehem Hospital, London,** *engraving from* **The Rake's Progress,** *1733*

cause although it is true that involuntarily hospitalized mental patients are often helpless, don't take good care of themselves, and don't seek help, still, ironically, there is one thing they are often very sure and decisive about: They don't want to be in a mental hospital, and they don't want anything to do with psychiatrists.

But we still haven't touched on the sorts of human situations—on the conflicts that tear apart families, on the dilemmas that persons must face—in which psychiatrists are typically expected to intervene. We need some examples again. I like to use literary examples. Say, Lady Macbeth. What's wrong with her? Well, I won't rehash the story. The point is that Macbeth has finally made it, all the way to the top. Now he can't enjoy his success because of his wife. She is upset. She can't sleep. She sees blood where there is no blood. Psychiatrists would now say she suffers from an agitated depression. But why is she depressed? Is she sick? That's what her husband would like to believe. He calls the doctor. But the doctor—that was four hundred years ago—knows why Lady Macbeth is depressed. Because she is guilty. So he tells Macbeth that hers is not a medical problem and beats a hasty retreat. Now, precisely that which the doctor in *Macbeth* says *is not* a medical problem, doctors now insist *is* a medical problem. This is as good an example of the medicalization of morals I can think of.

Of course, if you want to make the Macbeths' problem a medical problem, that can be done. Many people actually invite such a medical definition of life's problems. It is also possible to do things to women like Lady Macbeth as a result of which their husbands are likely to feel better. For example, it is possible to give her drugs so she won't remember and won't remind her husband of all the things they ought to feel guilty about. It is possible to give electric shocks to her brain—and that will work even better in wiping out her painful memories. I don't think these are good things to do to people. But these are judgments about which honest people can disagree. For example, some of my psychiatric colleagues say: "After Lady Macbeth gets electrotherapy"—that's what they call it now—"she'll feel better, she'll feel grateful for the treatment she got." Perhaps. But what does that prove? To me, it certainly doesn't prove that she was ill or that what was done to her was a treatment. There is a reason, after all, why Shakespeare didn't make Lady Macbeth come down with the plague, or make her run off with one of her husband's lieutenants. Those things would have spoiled Macbeth's success also. But they would not have made the point that Shakespeare wanted to make, that the play makes. The medicalization of morality is the point. That's

what we are talking about.

Miller: So what do you feel *ought* to be an offer to those people who are exhibiting either very florid, peculiar and distressing mental symptoms, or florid disorders of behavior, or thought, that are distressing either to them or to their relatives?

Szasz: To begin with, I would want to separate those two categories. We are dealing with two quite different populations here. Some so-called mental patients—people who are now called schizophrenic, depressed (Lady Macbeth, for example)—may themselves suffer. Or they may not suffer—for example, people with so-called grandiose delusions. The point is that we are dealing here with a group of people whose pattern of behavior upsets those with whom they live. Psychiatrists call such people disturbed, but it would be more accurate to call them disturbing. Now, for the sake of simplicity, let us assume that the so-called patient does not seek any help—at least, not through medical or psychiatric channels. In that case, I believe it is up to the disturbed relatives, friends, employers, and so forth to decide what they want to do, how they want to conduct themselves toward the disturbing, upsetting person. The upsetting person may, of course, be counseled or cajoled to change his behavior, to pursue one or another course; but, in my opinion, nothing should be done to him by force, against his will—as long as he does not break the law. *Primum non nocere*—first of all, do no harm—that is the classic Roman precept for the doctor in a quandary. It's a good precept. I think it could and should be applied to the way we treat so-called psychotic persons. Of course, if the person consents . . . well, then, there is no problem.

Miller: But I'm trying to indicate a type of patient who is not simply obstreperous, he's not causing distress to his relatives because he makes their life distressing . . .

Szasz: Give me an example.

Miller: Well, I'm talking about the personality changes that lead relatives, parents, siblings to say *not*: "Please cure my brother, sister, or father, because they are making our life appalling," but: "Please restore to us the person whom we love." Not: "Please make them less obstreperous—less insulting, less disgusting," but: "We would like back the lovable person with whom we've been associated all our lives."

Szasz: Ah! Hard as I may try—and without wanting to appear difficult about this—I can't deal with that. I can't deal with it, in that form, because a relative who would speak like that would already be denying the reality, the truth of what is happening in his life and in the life of his so-called loved one. Just as Macbeth was denying, or was trying to deny, how he got to the top—his bloody deeds.

It's all too abstract. We have got to have a concrete example. May I suggest one? Here is a fine young woman. She had been a good, healthy, lovable child. She was fine when she was ten, eleven, twelve years old. Then, when she gets to be thirteen, fourteen, fifteen, she begins to starve herself. She hardly eats. When she eats, she throws up. Pretty soon she looks like a skeleton. The psychiatrists say: "Ah, she has got anorexia nervosa." The parents say: "Give us back our wonderful daughter, just the way she was before she became ill; she was a healthy little girl, she ate normally, everything was fine."

Miller: Yes, but isn't that a perfectly legitimate and reasonable request?

Szasz: It looks like a legitimate request, but it's not because it denies all the reasons why this young woman doesn't eat—which, from her point of view, are just as legitimate as why a hunger striker in Northern Ireland doesn't eat.

Miller: But surely there is a fundamental distinction. Admittedly, the reasons the patient suffering from anorexia nervosa is deliberately abstaining from food may be metaphorically similar to the way in which the prisoner in the H-block is abstaining from his. She may be trying to get some sort of deal. But in the case of the H-block prisoner, the concessions that would call off the strike are clearly known. They're on the table. But in the case of the anorexic patient, it's almost impossible for anyone other than an expert, and perhaps a medical expert, to find out what concessions would get her to call off the strike.

Szasz: That's not so. Excuse me for being so direct. I think this may be a very instructive parallel, between anorexia nervosa and anorexia politica, as it were. The point you make is partly—and that part is correct—that nothing in the Irish hunger striker's motivation or goal structure is mysterious or repressed. We know why he doesn't eat. People can now accept and tolerate all the ideas involved in such a drama—who the hunger striker is, what he wants, what his adversaries want. That's where the difference lies between the self-starvation of a political prisoner and of a young woman in contemporary society. I'll have to oversimplify here a bit, but what I will say is, I dare say, correct. Whereas people now accept the motivation of an Irish hunger striker, they do not accept—they reject, repress, deny, call it what you will—that there are many young people today who, during adolescence, have one overriding goal—and that is not to grow up! Now, that is a pretty unpleasant fact, all right. And people can't tolerate it. So we call it schizophrenia, we call it anorexia nervosa, we call it all sorts of things, depending on how the young person displays her refusal to grow up.

So, the point is that most people can't tolerate that there are some young girls who don't want to become adult women, with everything that role implies for them; they don't want to become second-class citizens. Can you blame them—when that's how they have been treated for so long? They don't want to be sexually attractive, perhaps because that leads to having babies, which they may not want and so forth. You are right, of course, that what these women want is not a relatively straightforward political deal, like a prisoner might want. It is a more subtle existential deal; the protest is symbolic, is disguised. People are not prepared to hear such demands, much less to meet them; it may be impossible to meet them.

Miller: But nevertheless, for the family, this is a painful situation, and apparently will lead to a fatal outcome.

Szasz: But it's not a fatal outcome.

Miller: Well it *may* be a fatal outcome.

Szasz: No, no. Please. You are in the word business, you deal with language. When you speak about a fatal out-

come, you make it sound as if we were dealing with something like cancer or end-stage renal disease. But what we are talking about is a person, a young woman, who may prefer death to growing up as a woman. In 1400, she might have been called a saint. You know: "Give me liberty or give me death." There have been lots of people throughout history who have preferred one or another goal, even if it meant death, to a life on terms they deemed unacceptable. This raises the whole question of suicide—and that is a question that our society is especially loath to look at. We deny the legitimacy or rationality of suicide. It's a mental illness. I am not particularly advocating suicide . . .

Miller: No, but without denying the legitimacy of it one can understand relatives who would prefer it not to take place, and say: "Please do something to persuade our daughter *not* to kill herself."

Szasz: Now we are off to the races. The parents of a young woman or man may prefer all sorts of things; they may prefer that their son, if he is a nice Jewish boy, should not marry a Gentile girl; or that their daughter, if they like their son-in-law, should not get a divorce. Now we have shifted to talking about how some family members would like other family members to behave; especially how older family members would like younger family members to behave. That's got nothing to do with disease; that's got to do with power. Suppose that the father is an Orthodox rabbi and the son comes home and all he wants for lunch is a ham sandwich; so, where is the disease? But anorexia nervosa? Why is that a disease?

Miller: Well, to whom do they go in order to talk about it?

Szasz: That's their problem, their decision to make. I'm just trying to bring order to psychiatric chaos. I don't have an answer to every one of life's problems. I only know a stupid answer when I see one.

Miller: I recognize *that*. But in that case let's put ourselves in the position of the unfortunate complainer, whether it is a relative or the patient herself. To whom does she turn? *You* say it's not your problem—whose problem is it?

Szasz: Well, let me try to answer that in greater depth. You see, before we can deal with that question, we must distinguish between problems and problems. There are lots of problems in life. Let's call the first kind of problem scientific or technical, and the second kind moral or personal.

Suppose a person has pneumococcal pneumonia and he wants help with that problem. Then he should turn to someone who is an expert on treating pneumococcal pneumonia—and who has the appropriate chemicals, to which pneumonia responds.

But suppose someone has a family problem—about having children, divorce, religious differences. To whom should he turn for help? If he is going to do this right—right, as I see it, of course—then the decision must grow out of who he is. In other words, this is not a decision that can be made by determining who is technically most competent to help in such a situation; instead, it must grow—I am tempted to say, organically—out of who the person seeking help is. Let's assume that the troubled person is devoutly religious, that his whole family is devoutly religious—then, I think, it would be best for them if he sought help, if they all sought help, from a priest or a rabbi. On the other hand, if our hypothetical clients are not religious but are psychologically inclined, then it may make sense for them to seek help from a psychotherapist or a psychoanalyst.

You see my point? . . . I could go on. If the person with the problem is in love with medicine, with drugs, then he could go to doctors, take thorazine, have a transsexual operation—people seek all kinds of solutions for their problems, for the ways they interpret their problems.

Transsexual operations are a good case in point. I don't like them. But some people do. Officially, they are treatments. The American government, the American taxpayer, now pays doctors to operate on perfectly healthy men in order to make them into fake women, and *vice versa*. So, that gives you some idea of the range of choices people have when they try to solve their life problems.

Miller: So you're saying that whoever finds himself distressed should seek relief from some ethical source, rather than from some medical one.

Szasz: Yes, that's right. It's a mistake for people to seek relief for existential or spiritual difficulties through technological means. But it isn't just the medical methods that are faulty, that lead to a dead end. All the technicalized, pseudoscientific methods—for example, psychoanalysis and the other so-called modern psychotherapies—are fundamentally flawed.

You see, I look upon all of psychiatry as a religion, with various branches and types. Biological psychiatry, Freudian, Jungian, Reichian, this kind of "analysis" and that kind of "analysis"—direct, rational, transactional, you name it—just so many creeds and cults. To all this, I try to bring the point of view of a psychiatric atheist: of someone who observes, studies, comments on all these creeds, but who refuses to accept any of the cult-founders, any of the gurus, as scientists; who insists on calling their rituals rituals rather than therapies. This is why I said, a long time ago, that the trouble with evaluating psychiatric treatments is that, in psychiatry, everything works and nothing works. In short, all of the psychiatric "treatments" are fine, for those who believe in them.

If the psychiatrist wants to believe in a certain method—fine; if the patient wants to believe in it—fine. If they both believe in the same thing, let them get together—that's fine, too. All psychiatries, like religions, are okay, so long as they are practiced voluntarily, without coercion, without state intervention. All are objectionable if the state promotes them and pays for them. And all of them become evil if the state imposes them on people by force. That is my moral and political position on religions, psychiatry included. That position does not mean that I don't also have an intellectual opinion about them. I do, as I indicated already. I hold all contemporary psychiatric approaches—all "mental-health" methods—as basically flawed because they all search for solutions along medical-technical lines. But solutions for what? For life! But life is not a problem to be solved. Life is something to be lived, as intelligently, as competently, as well as we can, day in and day out. Life is something we must endure. There is no solution for it. ■